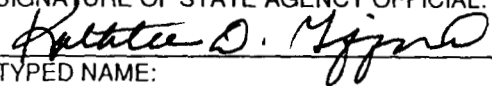
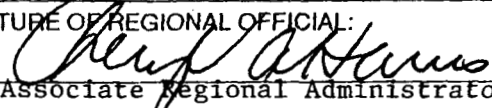


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>0 1 — 0 0 6</u>	2. STATE: Indiana
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2001	
		5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: CFR 435.121		7. FEDERAL BUDGET IMPACT: a. FFY <u>2001</u> \$ <u>31,305,721</u> b. FFY <u>2002</u> \$ <u>41,733,917</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, Page 6a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.2-A, Page 6a	
10. SUBJECT OF AMENDMENT: Statutory change in definition of disability			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Kathleen D. Gifford Asst. Secretary, OMPP 402 West Washington, Room W382 Indpls., IN 46204 ATTN: Tracy Brunner, Plan Coord.	
13. TYPED NAME: Kathleen D. Gifford			
14. TITLE: Asst. Secretary, Medicaid Policy & Planning			
15. DATE SUBMITTED: 3/29/01			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 3/30/01		18. DATE APPROVED: <u>4/23/01</u>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>01/01/01</u>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Cheryl A. Harris		22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health	
23. REMARKS:			

RECEIVED RECEIVED

MAR 30 2001

MAR 30 2001

DMCH - IL/IN/OK DMCH - IL/IN/OK

State: INDIANA

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

435.121

13. XX/ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

X Aged
X Blind
X Disabled
X Blind and disabled individuals receiving SSI and except for receipt of SSI would be eligible for AFDC. The more restrictive categorical eligibility criteria are described below:

1. In order to be eligible for MA as a disabled person, the applicant must be determined to meet the disability requirement set forth below. The Division of Family & Children, Family & Social Services Administration, has the sole responsibility for making this determination.

Definition of Disability: An individual is considered disabled if he has a physical or mental impairment, disease, or loss verifiable by a physician licensed under IC 25-22.5 that appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least four (4) years without significant improvement and that substantially impairs the individual's ability to perform labor or services or to engage in a useful occupation. In determining whether an individual is disabled, consideration is given to the existence of an impairment or a combination which, together with such factors as age, training, skills, and work experience result in disability.

(Financial criteria are described in
ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

Each County Welfare Department under the supervision of the Family & Social Services Admin.
TN No. 01-006 Approval Date Effective Date 1-1-01
Supersedes
TN No. 91-022 HCFA ID: 7983E